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The Role and Work of Forensic Nurses: An International Comparative Approach

A Project Report



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Background and aims

Forensic Nurse Examiners (FNEs) have been independently conducting forensic examinations on the survivors of rape and sexual assault since 2001. Introduced in order to cover the rota during the day (a time that is traditionally difficult for doctors given their various other roles), the introduction of nurses was an attempt to reduce the length of time that survivors (or clients as they are called by some nurses, a convention that I will follow throughout this report) had to wait to be seen by a forensic medical practitioner. The waiting time and the gender of the forensic practitioner were two longstanding criticisms levelled at forensic medicine by academic and feminist groups, and the introduction of nurses was a means of addressing both.

Following their initial introduction, the uptake of FNEs has been limited; only a small number of constabularies throughout England and Wales employ them (and in some cases have abandoned them after a short period of time), and in Scotland the rules of corroboration have meant that when they are used they are limited to the role of assistant, corroborating the findings of a Sexual Offence Examiner (SOE). However, given their cost-effectiveness compared to doctors, particularly at a time when the organisations that fund forensic medical provision (the police and the health service) are dealing with “austerity measures”, it is likely that the United Kingdom will see a rise in the employment in FNEs, especially as the burgeoning professional association concerned with forensic nurses, the United Kingdom Association of Forensic Nurses (UKAFN), is becoming more involved in organisational decisions.

At the same time as the development of FNEs, academic interest in the forensic intervention following sexual assault increased. There are now a number of scholars investigating the work of forensic medical practitioners in Canada, the United States of America and the United Kingdom. However, nearly all the studies thus far produced have focused on single jurisdictions, without really considering whether the findings from one country are generalisable to others. The introduction of nurses in the United Kingdom has enabled the comparison of the forensic intervention following sexual assault between that jurisdiction and others that use nurses, predominantly Canada and the United States of America. Not only has this

comparative analysis allowed for the evaluation of generalisability of social science work; it has also, more importantly, enabled the identification of examples of best practice alongside certain activities that (I would argue) are less beneficial. In addition, given the different lengths of time for which the nurses have been practising (Sexual Assault Nurse Examiners (SANEs) in the United States of America have been independently performing forensic medical examinations since the early 1990s), the analysis has also flagged up strategies that nurses in different countries have developed in order to avoid pitfalls or overcome contentious situations with other members of staff, notably doctors. As FNEs and UKAFN are still developing, the project was designed to provide nurses with examples of best practice and strategies for avoiding conflict with their colleagues, and also to highlight problems that other nurses have had to address in the past.

The specific objectives of the project were to find out:

1. How are FNEs and SANEs recruited and trained?
2. What is the relationship between doctors and nurses in the forensic examination of sexual assault survivors?
3. How do FNEs and SANEs negotiate the medical and legal aspects of their work?

And also to provide:

4. Feedback to FNEs and SANEs about reflections and best practice

In sum, the main agenda of the research was to ascertain how forensic nurses perform their work, and how geography and local legal differences influence forensic practice.

Methods

Having decided upon a comparative approach, it was necessary to choose a location to use as a comparator. Ontario, Canada was chosen, for two reasons: first, that the Network of Sexual Assault and Domestic Violence Treatment Centres (hereafter "Network") had already been the focus for academic research in the past, demonstrating that the Network was interested in this form of research (and also enabling the evaluation of generalisability of social science research), and secondly, that the Network is often exemplified as a model of best practice, which would enable me to pass on elements of best practice to UKAFN.

Observation is the preferred method for investigating work as practice; however, given the nature of the forensic medical intervention, it was deemed inappropriate to perform this kind of research. Interviews were chosen as the research method as they have been used successfully before, both by the author and by other scholars investigating forensic medical work.

Access to the Network was originally generated by the Network Co-ordinator, who also acted as gatekeeper. Three Sexual Assault and Domestic Violence Treatment Centres across Ontario were randomly selected from the 33 that perform forensic medical examinations on adults. Letters were sent to

the co-ordinators of the three centres, inviting them to choose two or three nurses for interview. Eight nurses were interviewed. In the United Kingdom, UKAFN granted me access to five nurses and two doctors across five centres. The doctors interviewed were involved in the training of FNEs. Ethical approval was granted by the University of Edinburgh Research Ethics Committee, as well as the Ethics Committees of the three Ontario hospitals. Each interview lasted between one and two hours and was based upon an interview schedule, but semi-structured, allowing space for probes and further reflection based upon the respondent's answers. Interviews were digitally recorded and transcribed verbatim shortly afterwards. The transcription process resulted in refinements to the interviews as the research progressed. Once the interviews were complete they were reviewed for key themes, upon which matrices were produced, enabling comparison both between respondents and between the two jurisdictions.

In addition to the interview material, I drew upon media reports, forensic medical guidance, protocol documents and an instruction DVD for medical practitioners produced by King's College Hospital, London. These documentary sources were analysed in the same way as the interview data.

Findings

1. How are FNEs and SANEs recruited and trained?

Nurses are generally recruited from either trauma medicine or gynaecology. In Ontario the centre often advertises internally for new recruits. Centre co-ordinators are aware that some nurses want the training in order to broaden their skills base but are not interested in staying long-term. To ensure that recruited nurses are truly interested in the work, some centres have a year-long recruitment process, involving multiple meetings with the applicant and shadowing of more experienced nurses in order to ensure that the new recruit has the appropriate temperament and attitude for the work.

In the United Kingdom, the majority of nurses that I interviewed were working in custody roles when asked if they would be interested in doing forensic examinations of sexual assault survivors. Others became interested in the role through interacting with SARCs in other aspects of their work (sexual health or gynaecology) and asked to become more involved. These nurses initially served as Crisis Workers, dealing with clients' emotional and social needs before the forensic examination, and were then asked to train as FNEs.

The recruitment practice in each jurisdiction partly ensures that the nurse has the appropriate attitude for the work; it is the training procedures employed that teach the nurse to practise with a non-judgemental attitude toward the client. During shadowing of more experienced staff, the nurse, in addition to observing how to perform the minutiae of the examination (which samples to take, how to record injuries, etc.) watches the manner in which the forensic practitioner interacts with the client. In some centres, before nurses can practise independently, their adoption of a similar non-judgemental attitude is assessed via a role-play exercise, with a member of a victims' advocacy service playing the role of the client. While the nurse must perform the examination competently (although in some centres the actual conduct of the genital examination is not conducted, with the nurse instead verbally explaining the procedures she would employ), she is actually assessed on the way that she interacts with the client:

but the main things that I watch for is what they are saying... sometimes you unknowingly say something that sounds terrible, you might say "oh I know you didn't mean for that to happen", or "I know it wasn't your fault", you have to be careful how you word that, you want them to know it's not their fault but sometime you can kind of suggest it, "surely when you dressed like that you didn't expect this to happen to you"

In Ontario, if the centre co-ordinators agree that the trainee nurse displays the appropriate attitude then she is free to perform independently, and after a year is invited to attend SANE training (again, the year's delay ensures that the nurse is committed to forensic work).

Recently, SANE training has started to focus on the legal requirements of the SANE role. In the past, nurses were also trained to perform gynaecological examinations; however, given that nurses normally have a year's experience by the time they attend SANE training, this is no longer considered necessary. Nowadays the focus is on the relationship between the nurse and other members of the criminal justice system, providing nurses with experience of the courtroom as well as allowing them to make contact with other legal staff. Once nurses have attended the SANE training they can officially label themselves SANEs. At the time of writing, the UKAFN have just announced the development of a postgraduate qualification in Advanced Forensic Practice with Stafford University that seems to have similar aspects to the SANE training, but with the added status of a qualification.

2. What is the relationship between doctors and nurses in the forensic examination of sexual assault survivors?

A substantial difference between the Ontario and United Kingdom nurses is their relationship with doctors. In Ontario, doctors do not wish to perform forensic medical examinations or provide evidence to court, and are happy for SANEs to fulfil that function. However, SANEs are not actually considered experts in the Ontario context, unless they prove themselves to be so during the court case (for example drawing upon the number of cases they have examined). Very few SANEs wish to claim this expertise, and instead rely

upon their documentation “to keep [them] out of court”. To this end, nurses perform the examination, including completion of documentation, and it is these forms that constitute the forensic medical evidence in the courtroom, with nurses very rarely having to provide testimony. If the prosecution do require expert reports, the centre co-ordinator (generally a SANE who works full-time) fills that role. However, they do not provide evidence about the specifics of the case, but rather generalities, for instance the finding that injuries are frequently not present on survivors’ bodies.

Doctors can be involved in the examination if the client has not been effectively medically cleared before the examination, and (for example) is found to have a large injury that requires treatment beyond the nurse’s capabilities. SANEs did comment that sometimes a doctor would attempt to pull rank and would complain about nurse involvement; however, when this happened, the nurse would rely upon their specific training in the care and treatment of the survivor and ask the doctor to assess what was in the client’s best interest. Overall, SANEs said that they had a good working relationship with doctors, and stated that over time they had developed different skills that enabled both to conduct their roles.

This division of labour is yet to happen in the United Kingdom, which is possibly due to the novelty of forensic nurses. FNEs felt strongly that doctors did not want them involved in the forensic medical examination as the latter believed that the former would not do a thorough job; in at least one constabulary, doctors had even withdrawn training from nurses. As in Ontario, nurses can conduct the examination and their report is disclosed to the prosecution and defence. However, if the prosecution require an expert report, a doctor is usually requested to prepare a report on specificities of the case based upon the nurse’s documentation. Keeping this belief that nurses will not conduct a thorough examination in mind, and aware that doctors may be requested to write an expert report based upon their documents, FNEs are anxious not to omit any information from the forms.

Comparing the work with that of Ontario again, SANEs generally have two types of nursing documents: standardised protocol with tick-boxes, or open-ended paperwork in which they note down the client’s answers to highly specific closed questions

which the nurse has been trained to ask (number of assailants, use of a condom, etc.). To this end, the nurse only records information either expressly requested upon the form or of the type that they have been trained to generate; this way, if the client does mention other information that is not requested on the forms (previous terminations of pregnancy for instance), the nurse does not have to record it.

FNEs, in contrast, were found to record additional information that was not specifically requested on their standardised protocol documents. Although nurses agreed that information regarding (to continue using the above example) termination of pregnancies was irrelevant to the case and was not asked for on the form, they would still add it to their documentation, arguing that it may become relevant to the doctor’s expert testimony. Moreover, in an effort to prove that they have performed the examination thoroughly, they consider it best practice to record all physical phenomena, including tattoos and piercings, as by doing so the nurse can show the court that she has examined the client from top-to-toe. Both of these practices are problematic, as the nurses’ reporting documents are disclosed to both the prosecution and defence, and scholars who have investigated the use of sexual history and bad character evidence in sexual offence cases have demonstrated that the defence employ evidence such as previous terminations of pregnancy, intoxication, multiple sexual partners, tattoos and piercings (amongst other things) in order to discredit the complainant during cross-examination. It is troubling, therefore, that such information is being recorded on disclosable documents, and moreover, that the reason for the recording is due to a professional conflict between doctors and nurses, the result of which is that FNEs are recording irrelevant and frequently prohibited information in order to avoid claims that they have not performed the examination in a thorough manner.

3. How do FNEs and SANEs negotiate the medical and legal aspects of their work?

The temporal and spatial aspects of forensic nurse work were investigated in order to understand the ways that FNEs and SANEs managed the medical and legal requirements of their work; this raised questions about the nature of shift work and the type of person who could serve as a forensic practitioner. Turning initially

to the medical and legal aspects of forensic work, it is clear from the ways in which nurses use the spaces in which they work whether they emphasise the therapeutic or evidence-gathering aspects. The Network places considerable emphasis upon client empowerment, and it is the SANE's role to uncover and provide the medical and legal options that are available to the client (collection of trace material, contraception, prophylactic medications, etc.) SANEs are acutely aware that the police put pressure on clients to have trace material collected ("doing a kit") and so they ensure that clients are taken into the examination suite, a room the police are prohibited from entering, very soon after their initial arrival in order to ascertain that the client does wish to be there and is provided with all the options as to the ways in which the examination will proceed.

However, if the client does agree to "do a kit", the SANE's use of the space changes. SANEs are very aware of the "chain of custody" and take great care in ensuring that, once open, the evidence-collection kit does not leave their sight, so that they can claim (if they are required to go to court) that there is no way that the evidence could have been tampered with. The Network's centres are based within the buildings of hospitals, enabling quick turnarounds on blood chemistry and other pathology tests necessary to know which medications to prescribe. If the kit has been opened, the nurse is required to carry it with her if she goes to the pathology laboratory. Leaving the kit could break the chain of custody. Once the kit is open, therefore, the space is as evidential as it is therapeutic.

Moreover, SANEs talked about the rest of the hospital as "chaotic" and potentially traumatising for the client, compared to the "warmer and fuzzier" Sexual Assault and Domestic Violence Treatment Centres. SANEs believed it was their job to get the clients out of the chaotic environment as soon as possible and into the centre, although they also stressed that they needed to prepare the client psychologically for walking through the rest of the hospital, particularly if they were escorted by the police or had torn clothing.

UK Sexual Assault Referral Centres are located in purpose-built buildings on hospital property and so FNEs do not have the same concerns about moving clients through the hospital. The potential for contamination of evidence is a chief reason for

placing SARC's in separate buildings; that way, they can have specialist cleaning protocols independent to the rest of the hospital. Examination rooms are regularly cleaned, and often nurses clean the suite both before and after an examination. Likewise, FNEs wear scrubs and gloves to limit the potential for contamination. The focus on cleanliness and avoiding contamination demonstrates a high degree of emphasis on evidence-collection. This echoes the guidance offered by organisations involved in the setting up and running of SARC's, for example the Association of Chief Police Officers (ACPO). However, like SANEs, who emphasise the therapeutic over the evidential until the opening of a kit, FNEs put a strong emphasis on the care of the client, and often stay after the end of their shift or come in outside their usual work hours in order to make sure the rota is covered and to ensure that the client is seen by only one nurse instead of being handed over to another. These practices are appreciated by clients, and FNEs often informed me that clients had visited the centre some time after the examination to thank them.

Of course, this flexibility (being able to stay late and fill in gaps on the rota) comes at a cost, and requires a certain kind of family or out-of-work lifestyle. SANEs emphasised how their out-of-work life was shaped by being "on-call"; while they did not have to stay at the centre when not on shift, they were expected to be at the hospital within 45 minutes of receiving a call. This limited their choice of accommodation and the activities in which they could engage when on-call. Others found it difficult to be flexible and had other priorities. This conflict resulted in some nurses having to make difficult and highly emotive decisions regarding whether to accept a call towards the end of their shift (knowing it meant that they would be staying at work for at least the next three hours) or to leave the client waiting until the next person. I was informed that this conflict had resulted in the burnout of some nurses, leading to their eventual departure from forensic work. In order to be successful forensic practitioners, nurses must discipline themselves, their lives and sometimes their family lives in order to provide the high standards of care that forensic work demands.

Provisional Recommendations

4. Provide feedback to FNEs and SANEs with regard to reflections and best practice, including potential pitfalls

Recruitment and Training

In my opinion, best practice is found in centres where there is an extended period of time between the application to work as a forensic practitioner and the commencement of training and independent practice. This period enables multiple interviews between centre co-ordinators and applicants in order for the former to assess the suitability of candidates, in particular to ascertain whether they are merely looking to develop their CVs. Moreover, recruiters may have to pay attention to the flexibility of an applicant and any outside priorities they may have that may prohibit them from providing a high standard of care. An extended apprenticeship period would enable recruiters to assess the flexibility of the nurse.

Clearly, this kind of extended recruitment and apprenticeship period is not always possible given time and financial constraints; as such, I strongly recommend the use of role-play exercises where nurses' attitudes and interactions with clients are assessed in addition to their procedural abilities, and that it is made clear to applicants what pressures will likely be put on them to organise their lives around the work.

With regard to the new UKAFN degree, there may be some benefit in following the lead of the Ontario Network; SARCs could introduce a policy of only paying the qualification fees for nurses who have committed to working for the SARC long-term. Clearly, turnover of staff has been a problem in Ontario, and it would be inadvisable for SARCs to train nurses who will not remain employed for a period, as this does not make the cost of training worthwhile.

- 1 Role-play exercises and extended recruitment periods to assess temperament of nurse applicant
- 2 Local training before payment for Advanced Forensic Practice Qualification

Doctor/Nurse Relationship

Closer collaboration between doctors and nurses is vital in the United Kingdom in order to improve the confidence of FNEs. This, in turn, will reduce the quantity of irrelevant and problematic information being recorded on disclosable documents. Following the Ontario Network's example, a doctor should be available to nurses by telephone at all times. If a client reports information that is not requested on a standardised form or has a physical mark of uncertain relevance, nurses can then contact the doctor to ask whether they should record it.

Following this, I would strongly advocate for standardised recording documents in both Ontario and the United Kingdom. I would also advise that nurses should, as far as possible, limit their documentation to the information specifically requested upon the forms (unless they have been told by another authority that something else is relevant). This would enable the nurse to ask open questions, which the client has the opportunity to answer as fully or as briefly as they want, with the nurse recording the information requested on the document. In addition, I also recommend that either a legal scholar or a social scientist aware of rape shield legislation is involved in the development and evaluation of the recording documents.

- 1 Standardised protocol documents prepared collaboratively by forensic medical experts, forensic scientists, the police and academics
- 2 SOEs accessible by telephone

Medico-Legal Space

More thought could be given to the location of centres in Ontario. SANEs themselves were often critical of having to walk clients from the chaotic ER through the various wards to the centre. Moreover, centres were often located within obstetric-gynaecology wards; while this is clearly beneficial for access to technologies, it may be problematic for clients worried about unwanted pregnancies and male clients. Perhaps the separate centre, although more expensive, would prove more beneficial in the future.

- 1 Reflection on location of Sexual Assault and Domestic Violence Treatment Centres within the building of the hospital, particularly when located near obstetric and gynaecology wards.

Outputs

Journal Articles

Rees, G., White, D. (Forthcoming) “[C]urb[ing] the atrocity of rape once and for all’: An analysis of online discourse surrounding an anti-rape technology” *Women’s Studies International Forum*

Rees, G (Under Review) ““Well nurse, you’re not very good because she’s actually got a tattoo on her back”: Professional authority and relevance in forensic medical examinations of sexual assault survivors” *Journal of Law and Society*

Rees, G (Under Review) ““With the disruption to your family life, it’s more a vocation than a job”: Flexibility, Favours and Family in the Forensic Nurse Examination of Sexual Assault Survivors” *Gender, Work and Organization*

Chapters

Rees, G (Forthcoming) “Contentious Roommates? Spatial constructions of the therapeutic-evidential spectrum in medico-legal work” in Harper, I., Kelly, T., & Akshay, K. (Eds.) *The Clinic and the Court: Medicine, Law, Anthropology* (Cambridge: Cambridge University Press)

Rees, G. (Forthcoming) “Colposcopy in the Courtroom: The medico-legal management of a controversial visualisation device” in Cloatre, E. & Pickersgill, M. (Eds.) *Law, Science and Society: The Making of Knowledge, Technology and Socio-Legal Order* (London: Routledge)

Invited Speaker

Rees, G. “Contentious Roommates? Spatial constructions of the therapeutic-evidential spectrum in medico-legal work” presentation at “Clinic and the Court” workshop, University of Edinburgh, May 2011

Rees, G. Discussant on medical evidence at “Issues in the Production and Assessment of Evidence During Asylum Claims” symposium, University of Edinburgh, April 2011

Conference Presentations

Rees, G. “TBC” Comparative Analysis of Institutional Responses to Rape Annual Meeting, Glasgow, October 2011

Rees, G. “The Work of Forensic Nurses in Sexual Offence Examinations: An International Comparative Approach” presentation at the United Kingdom Association of Forensic Nurses Annual Conference, Stafford, September 2011

Rees, G. “[W]ell nurse you’re not very good because she’s actually got a tattoo on her back’: Professional authority and relevance in forensic nurse examinations of sexual assault survivors” presentation at Law and Society Association Annual Conference, San Francisco, May 2011

Rees, G. “[W]ell nurse you’re not very good because she’s actually got a tattoo on her back’: Professional authority and relevance in forensic nurse examinations of sexual assault survivors” presentation at Social and Legal Studies Association Annual Conference, Brighton, April 2011

Rees, G. “Observing the Medico-Legal Gaze” presentation at Comparative Analysis of Institutional Response to Rape Network inaugural meeting, Trent University, Ontario, July 2010

Events Organised

Rees, G., White, D. “The Social Study of the Forensic Intervention in Cases of Rape and Sexual Assault – Inaugural Meeting of the Comparative Analysis of Institutional Responses to Rape Network” Trent University, Wednesday 21st to Friday 23rd July 2010

About the author

Dr. Gethin Rees is a lecturer in Criminology at the University of Southampton. This research was conducted while he was an Economic and Social Research Council (ESRC) Research Fellow in the sociology department at the University of Edinburgh. Previously he was an ESRC Postdoctoral Fellow, again within Sociology at the University of Edinburgh. His interests are the interrelationship between medicine, science and the law, in particular the way that forensic medicine is produced and employed in rape and sexual offence cases.

Dr. Rees has been a visiting fellow at the John F. Kennedy School of Government at Harvard University and the Sociology Department at Trent University, Ontario. At the latter he co-founded the Comparative Analysis of Institutional Responses to Rape Network (CAIRRN), through which he will continue to conduct comparative studies of the forensic response to rape and sexual assault.

Dr. Rees has received mentoring support from Professor Lynn Jamieson, Sociology, University of Edinburgh, Co-Director of the Centre for Research on Families, and Relationships and expert on the use of sexual history and character evidence in rape trials.